STANDARD OPERATING PROCEDURE
Sentinel Events/Root Cause Analysis

SOP 15.8.2

Rev 6/02

Revisions: Added more detailed description of RCA process and included a chart that specifies areas to be reviewed and/or /discussed by the RCA team.

PURPOSE: DEFINE "SENTINEL EVENT" AND DESCRIBE PROCESS TO BE USED IN IDENTIFYING A SENTINEL EVENT AND CONDUCTING A ROOT CAUSE ANALYSIS

A SENTINEL EVENT is defined as an unexpected occurrence involving death, serious physical or psychological injury, or the risk thereof. Serious injury specifically includes a permanent loss of limb or function.

I. Sentinel event criteria

A. Unanticipated death (not expected or foreseen) of a detainee while at a Service Processing center or at another facility to which a detainee was transferred for medical care.
B. Attempted suicide, suicide, serious injury, loss of limb, or permanent loss of function.
C. Serious medication error.
D. Patient abuses (physical, sexual, or psychological) by medical clinic staff personnel.

II. Notifications, documentation, and investigation

A. The Health Services Administrator (HSA) or designee, of the SPC will:
    1. Complete an Unusual Incident Report and immediately begin gathering information about the event.
    2. Immediately notify the Medical Director and Chief of Field Operations.
    3. Initiate immediate risk reduction strategies as indicated.

B. The Clinical Director and HSA will assemble a review team within 72 hours, or 3 Business days, of the event to:
    1. Review circumstances, investigative data, and determine if additional information is needed.
    2. The HSA will submit a preliminary report of available information within 7 days of the event to the Medical Director and Chief of Field Operations. They will review the event and collaboratively determine if the event meets sentinel event criteria and requires a root cause analysis. The DIHS Director will decide if the event will be voluntarily reported to JCAHO.

C. If it is determined that that the event may be "sentinel," a root cause analysis will be initiated within 7 days of the event. It will be completed and submitted to the Medical Director for review and approval no later than 21 days after the event.

III. Root Cause Analysis (RCA) process

A. The RCA coordinator will be responsible for coordinating all aspects of the RCA in collaboration with the Division of Immigration Health Services, Medical Director, Chief of Field Operations, and local HSA.

B. The team will consist of at least four members including the Medical Director or designee, persons having knowledge of the event, and at least one representative from national Headquarters. The team is not limited to clinic staff and should include representation from any other stakeholders.

C. The HSA will keep the Medical Director and Chief of Field Operations informed of the teams' progress, identified issues, areas of concern, and risk reduction strategies, either verbally or in writing. The "draft" RCA will be submitted to National Performance Improvement Committee (NPIC) for review/approval within 20 days of the event. After review/approval, the NPIC will forward the RCA to the Medical Director for final approval. The Medical Director will schedule the RCA for review by the Executive Council.

D. The HSA will be responsible for implementation of all local risk reduction strategies recommended as a result of the RCA. Implementation of risk reduction strategies for system-wide issues will be implemented through the NPIC.

E. Follow up and status reports will be submitted to the Medical Director as required by the RCA.

IV. Conducting the Root Cause Analysis

The Root Cause Analysis Process will include the following:

A. Development and review of a detailed sequence of events.
B. Identification of involved processes.
C. Flow chart of each identified process as intended to be conducted.
D. Flow chart of each selected process as it is routinely/was conducted.
E. List each step and each link between steps of the intended process
F. Identification of discrepancies between the flow charts.
G. Identification of Failure Modes and potential effect
H. Development of Risk Reduction strategy and mechanism for measurement.

Conducting the Root Cause Analysis

Detailed review of each of the following areas will be conducted based on the type of sentinel event. Review of areas not listed will be conducted as appropriate to the specific event under review.

Sentinel Event	Suicide/ Suicide Attempts	Med Error	Procedural Complication	Treatment Delay	Restraint Death or Injury	Death	Assault, Rape, or homicide
Behavioral Assess. Process	X				X	X	X
Physical Assess Process	X				X	X	
Patient ID Process		X					
Patient Observ. Procedures	X				X	X	X
Care Planning Process	X		X		X	X	
Staffing levels	X	X	X	X	X	X	X
Orientation & Training	X	X	X	X	X	X	X
Competency Assessment	X	X	X	X	X	X	X
Supervision of Staff		X	X	X	X		
Communication Patients/Staff	X			X	X	X	
Availability of Information		X	X	X		X	
Adequacy of Tech. Support		X	X				
Equipment Maintenance & Management		X	X				
Physical Environ/Security	X	X	X		X	X	X
Control of Meds, Storage, Access		X					
Labeling of Medications		X				X	